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CURRENT TOPIC

African children in Britain

Anne Nesbitt, Margaret A Lynch

Historical background

African children have been living in Britain since the 16th century. Brought by slave traders they were advertised, auctioned, and sold as servants in Bristol, Liverpool, and London. They often worked in aristocratic households and are portrayed in groups of the period by Zoffany and Reynolds.[1]

After the abolition of the slave trade Britain's black community divided and intermarried. From the mid 19th century small numbers of West Africans, mainly unaccompanied men came to Britain to study law, theology, and medicine at the behest of parents, missionaries, and philanthropists. In 1950 there were 90 African students in Britain, towards the end of the 1960s as independence became a reality, the numbers had increased tenfold.[2]

A Colonial Office report of 1955 recognised the isolation and discrimination experienced by students and actively encouraged accompanying families.[3] The difficulties they experienced are well described in Buchi Emecheta's semiautobiographical novel *Second Class Citizen*.[4] The period of stay in Britain often exceeded five years, but most students eventually returned home to significant positions in government service.

The optimism and high expectations that followed independence have not always been fulfilled. Most African countries face major debt crises for the foreseeable future. Civil wars, political instability, population pressure, and drought have exacerbated their difficulties and resulted in a diaspora of the African urban middle class, often to countries with old established links, but also to the Middle East and southern Africa.

Population statistics

The Labour Force Survey (1988) estimated the settled African population in Britain was about 122 000. This represented an increase of about 30% since 1981.[5] Since 1988 acceptances for settlement in Britain to African nationals have doubled to around 8000 per annum. In 1990 African children accounted for 1350 of these acceptances. In the same year, leave of entry was granted to 113 000 Nigerians, 38 700 Ghanaians, and 10 800 Sierra Leoneans.[6]

Applications for refugee status and asylum in Britain have increased tenfold over the past three years to an estimated total of 50 000 for 1991, with a substantial majority of applicants coming from Somalia, Ethiopia, and Uganda.[7] Recent applicants have included unaccompanied children.

The Labour Force Survey of 1986 identified 71% of Britain's African population as living in metropolitan areas. London was home for 81% of the total,[8] and other cities with significant African populations included Birmingham and Liverpool. In 1987 African children represented 4·7% of the total state school population in London. The highest proportions of African schoolchildren were in the Boroughs of Hackney, Lambeth, Southwark, and Wandsworth.[9]

The number of live births in the UK to mothers born in Africa has increased from 3593 in 1985 to 4721 in 1989, an increase of 35% over four years.[10 11]

Studies relating to a neonatal haemoglobinopathy screening programme in a south London health authority identified the proportion of births to mothers born in Africa as rising from 6·1% in 1981 to 14·5% in 1989, the total number of births per year remaining constant (unpublished data interim report on Camberwell neonatal haemoglobinopathies screening programme 1990).[12]

Regretably the methods of collection of ethnicity data in medical and sociological studies are not always clear or consistent. Information relating to African children and families has often been aggregated into the simplistic categorisation of 'Afro-Caribbean' masking important differences within the group and making interpretation of findings difficult.

Social circumstances

African families living in Britain share many of the problems faced by all families living in inner city and urban areas, but they differ in their expectations, aspirations, and supporting social networks. Recent editions of *African Women*, a development journal published by African women in Britain, have drawn attention to some of the perceived difficulties of the African Community.[13]

The expectation of a recently arrived refugee family is as a safe haven for the vulnerable family members during the period of war or repression in their home countries. Most want to return, preferably with new skills to offer to their society. The most recently arrived refugee families are mainly from the Horn of Africa, but also include asylum seekers from Kenya, Angola, Sudan, and Zaire. Families are often fragmented with husbands and older sons left behind, their whereabouts unknown. English language skills are initially limited and trained interpreters scarce, limiting access to benefit rights, health care, and training programmes. Accommodation is frequently in homeless family units or 'bed and breakfast' establishments.

Optimum Health Services, Newcomen Centre, Guy's Hospital, London
Anne Nesbitt
Margaret A Lynch

Correspondence to:
Dr Anne Nesbitt,
Community Health Services,
Elizabeth Blackwell House,
Wardalls Grove,
Avonley Road,
London SE14 5ER.

The expectations of a family from West Africa were previously educational but are now primarily economic. The per capita income in Nigeria has fallen from $1000 year in 1983 to less than $250 in 1990 and employment opportunities have disappeared. Employment opportunites in Britain have been reduced by the current recession forcing professionally qualified Africans into low paid casual work with catering, cleaning, and security firms. The financial pressure to remit money home to the extended family often forces both parents to work.

The distinctions between being a visitor, a student, an economic migrant, and an asylum seeker are often blurred. The rapid changes in Africa can mean that today's visitor or student becomes tomorrow's asylum seeker. Economic pressures convert today's *bona fide* student to tomorrow's economic migrant; political instability changes today's president to tomorrow's refugee.

Childcare

Childcare presents a problem for all working parents, particularly for the West African mother used to family support. Local authority day nursery places and college creche places are limited and play groups and nursery classes are rarely full time. Private nurseries are prohibitively expensive and registered child minders charge over £50–60 a week. After paying overheads there is little left from a casual worker's salary. One of the child care options is a well organised partnership with the child's father which can work successfully where one partner is a student or works a shift system.[14] Another option is that the child/children are fostered in West Africa by a member of the extended family, often grandmother. This is a culturally accepted practice, but is unattractive at times of economic hardship in Africa. A third alternative is a private fostering arrangement in Britain. The costs are similar to those of a daily child minder and allow the parents additional flexibility to work long unsocial hours and increase their earning capacity.

The practice appears to have begun in the mid 1950s at the time of the Colonial Office policy change and is well established in parts of Suffolk, Hampshire, Avon, mid Kent, and Sussex. It is estimated that there are between 6000–9000 privately fostered children in Britain at present, the majority of west African parentage. In a study of 81 children of African born parents entering south London primary schools between 1988–90, 29 (37%) had been fostered in Africa or Britain for varying periods before school entry (A Nesbitt, unpublished MSc thesis, 1990 University of London).

Some foster placements were and are successful but the quality of others has been questioned. The Commonwealth Student's Children's Society and latterly the Save the Children Fund's African Family Advisory Service (AFAS) have tried to contain, monitor, and support private foster placements. Concerns identified by AFAS have included minimal knowledge of the children's background, culture, and medical history by the foster parents, limited information about the children's natural parents, some of whom were known to have returned to West Africa (usually Nigeria), children being passed between foster families, understimulation and educational underachievement, inadequate use of medical services by foster parents, and confusions in the children about their racial identity.[15]

AFAS was subsequently contracted by the Department of Health to advise of the draft regulations on private fostering in the 1989 Children Act. Under the regulations now in force local authorities are required to develop systems of notification from foster parents, birth parents and third parties, including health and education workers. In the guidelines the importance of delegating responsibilty of consent for medical treatment is stressed, as is the transfer of medical and parent held records and adequate information to foster parents about the child's medical history.[16] While the regulations and guidelines offer a model of good practice, it remains to be seen whether the resources and personnel needed to implement it are in place.

Some West African families become foster parents themselves, fostering in Britain older children from the extended family in Africa, continuing a long established traditional practice. This group of children appear particularly vulnerable as they try to adapt simultaneously to a new country, family, and educational system.

Drug related offences

The economic pressure in West Africa have led to increasing numbers of Africans, particularly Nigerians, becoming involved in the importation of drugs. There are at present approximately 300 West African women in British prisons serving sentences between three and 12 years, many for drug trafficking offences.[17] A significant number of these women have children either in Britain or in West Africa. Children in Britain at the time of their mother's arrest are usually placed in local authority foster care, with attempts being made to continue mother-child contact by prison visiting schemes. At the end of the sentence mother and child are usually deported immediately. Nigeria's Decree 33 enacted in October 1990 and yet to be tested indicates that convictions for drugs offences overseas may result in a further prison sentence in Nigeria. The African community in Britain has been active in improving welfare services for African prisoners and their dependants.

African communities in Britain face the task of adapting to a new country in its own economic recession, at the same time shouldering responsibility and anxieties for their families in Africa.

Health needs

ANTENATAL AND NEONATAL SERVICES

The infant mortality rate for children born in the UK of African born mothers (excluding East Africa) was 11·2 per thousand in 1989 compared with an overall rate of 8·3 per thousand. The neonatal mortality rate for babies

of African born mothers for 1989 was 7·4 per thousand compared with 4·7 per thousand for babies of UK born mothers.[11] However, the aggregated postneonatal mortality rate for babies of African born mothers (1982–5) was lower than that of babies of UK born mothers, with lower mortality rates for diseases of respiratory system and sudden infant death.[18] The stillbirth rates to African born mothers has increased from 6·6 to 7·8 per thousand over the 1985–9 period. The overall stillbirth rate in 1989 was 4·7 per thousand.[10 11]

Birthweight distribution for infants of African born mothers over the period 1982–5 was similar to that for infants of UK born mothers.[18] Black North American infants of low birth weight have been shown in a number of studies to have lower neonatal mortality rates from respiratory distress syndrome.[19 20] A study from south east London, which compared 'British', 'West Indian', and 'African' births found no significant difference in perinatal mortality among very low and low birthweight babies.[21]

The raised stillbirth and perinatal mortality rates in babies of African born mothers have implications for antenatal and special care infant services. A tendency for 'late booking' by African (and Asian mothers) in a south London antenatal clinic has been recorded.[22]

HAEMOGLOBINOPATHY SERVICES

Carrier rates for haemoglobinopathies in parts of Africa are high. In western Nigeria there is a 25% carrier rate for haemoglobin S, with a 2·5% incidence rate of sickle cell disease. Awareness of sickle cell disease in the African community is low. In contrast, the West Indian community has actively lobbied for the provision of improved services and health education programmes. African children now represent the largest user group in a number of the established sickle cell centres in Britain. In 1985, the Runnymede Trust Survey discussed the patchy and *ad hoc* nature of sickle cell anaemia services in Britain.[23] Since then, funding for already limited neonatal screening programmes has been under threat and with the new NHS cross boundaries purchasing arrangements, high priority has not always been given to the provision of quality care for children with haemoglobinopathies. Ideally the facilities should include access to information, screening and counselling, as well as specialist paediatric input.

HEPATITIS B IMMUNISATION PROGRAMMES

The high prevalence rates of chronic carriage of hepatitis B surface antigen in African countries results in increased morbidity from liver disease and a raised incidence of hepatocellular carcinoma. Carrier rates in African women are probably up to 30%, with vertical transmission from mother to baby being closely linked to the mother's e antigen status. Perinatal vertical transmission rates in Africa and in the West Indian community in Britain are quoted as being between 0·3% to 5%.[24–26]

Policies for neonatal hepatitis immunisation in Britain at present vary. Some districts screen all women antenatally, immunising babies of e antigen positive mothers, others have a selective screening programme, yet other districts are now immunising all infants at birth. Maintaining high uptake rates for the second and third doses of vaccine is difficult as parents have often been poorly prepared antenatally about the reasons for immunisation. The long term international solution is the incorporation of an affordable vaccine into infant immunisation schedules; in Britain in the short term policies need to be rationalised.

SERVICES FOR HIV POSITIVE FAMILIES AND CHILDREN

The high prevalence rates of seropositivity to HIV in parts of Central Africa are well documented. Two London departments of genitourinary medicine have reported increasing numbers of HIV positive adults from Africa, particularly Uganda.[27 28] A 2% seropositivity prevalence rate is reported among African women attending a south London antenatal clinic.[22] Small but in service terms significant numbers of African children and adults living in London have developed full blown AIDS. Existing services have not been geared to the needs of African women and children living in social and cultural isolation. Medical management is at present based in major centres, but local support systems are developing.

BCG IMMUNISATIONS

BCG immunisation policies for African children in Britain may need to be reviewed. The incidence rate of tuberculosis in Somalia was rising before the outbreak of civil war[29] and notification rates in many African countries are high, with an increase in HIV related tuberculosis being reported world wide. At present the majority of children arriving from Africa have received a BCG immunisation neonatally, in some areas of Britain their siblings will also be immunised at birth, but in other areas immunisation will be at about the age of 13 years unless specifically requested by parents.

DEVELOPMENTAL DIFFICULTIES

Epidemiological data relating to developmental delay and disabilities in children of African born mothers in Britain is not available. There is a perception among educationalists and doctors that there may be an increased incidence of language and communication disorder, a pattern that has been noted in other immigrant communities (L Wing, unpublished data cited in Akinsola and Fryers).[30 31]

Again, there are service implications as well as the cross linguistic and cultural therapeutic challenge.

FEMALE AND MALE CIRCUMCISION

The term female genital mutilation is now being advocated to cover the different forms of female circumcision practised in Africa. 'Surgery' is

radical in Sudan, Eritrea, and Somalia; less radical in Ethiopia and Sierra Leone. The procedure constitutes and offence in Britain under the Prohibition of Female Circumcision Act of 1985. Under the Children Act a Prohibited Steps Order can be made where necessary to prevent parents carrying out a particular act without the consent of the court—for example removing a child from Britain so that mutilation can be carried out abroad. FORWARD (the Foundation for Women's Health Research and Development) has led the campaign against female genital mutilation in Britain and has outlined action of strategies when proposed female genital mutilation in Britain is suspected.[14] They emphasise the importance of medical practitioners, nurses, midwives, social workers, and teachers being aware of the practice. Many African women in Britain speak openly of their own experiences and of their wish to protect their daughters from traditions and practices imposed by elderly female relatives.

Circumcision for many young African boys takes place in the newborn period. In West Africa, it is typically carried out by the midwife in hospital in the days immediately after delivery. In Britain hospital based circumcisions are hard to access and rabbinical services are frequently used. The Children Act guidelines for privately fostered children in Britain suggest that male circumcision should be carried out by a hospital or clinic based service and by a medical practitioner.[14]

CHILD ABUSE

Professionals in the field of child abuse and neglect in Britain and Africa have experienced little difficulty in reaching a consensus about what it constitutes as was demonstrated at a recent international conference (B Oloko, International Workshop on Child Abuse and Neglect, Lagos 1990). African communities, in general, condone physical punishment of the naughty older child, with extended family members controlling this effectively if it is excessive. In Britain, when the African nuclear family is under stress, physical punishment can get out of hand, leading to the instigation of child abuse procedures. Child protection agencies, however, have little experience in working in partnership with African families and can easily alienate families with what is perceived as confrontational interference. Conversely agencies by recognising traditional child rearing practices and giving them undue weight can neglect the child's needs.

Conclusion

In today's world of upheaval and change, professionals working with children in Britain must be willing and interested in realising an international perspective on child welfare in their day to day practice. They need to be responsive to the rapidly changing needs of Britain's immigrant communities.

The 1989 Children Act has the expectation that the ethnic background of the child and family will be taken into account when working with priorities and decision making. In December, 1991, the UK ratified the United Nation's Convention on the Rights of the Child. Its articles state the right of all children to enjoy the highest attainable standards of health, access to facilities for the treatment of illness and rehabilitation to health. In addition it states that protection be offered to refugee children. This legislation and the intent of the convention should offer a firm foundation on which to build effective flexible health services for all ethnic communities. Ultimately this will depend on strong equal partnerships with community leaders and commitment to the ideal that all children deserve to achieve their potential and enjoy their childhood.

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